6100. PART B PROVIDER ACCESS TO LIMITED ELIGIBILITY DATA

Allow only Medicare participating Part B physicians and suppliers and their authorized billing agents automated access to beneficiary eligibility data as long as the provider bills electronically in the National Standard Format (NSF) or the ANSI X12 837 Transaction Set. Disclosure of Medicare eligibility data is restricted under the provisions of the Privacy Act of 1974, 5 U.S.C. §552a. Under limited circumstances the Privacy Act permits us to disclose information without prior written consent of the individual to whom the information pertains; one of these is for "routine uses;" that is, disclosure for purposes that are compatible with the purpose for which we collect the information. In the case of Part B provider access, a routine use exists which permits release of data to providers and/or their authorized billing agents for the purpose of preparing an accurate claim.

Providers will utilize existing on-line networks and telecommunications capabilities. There will be no funding to build new networks. You must use HCFA national eligibility data. You will display the data according to the technology being used. The data elements to be made available to providers are:

- HICN;
- Beneficiary:
  - Surname/first initial;
  - Gender;
- Entitlement date;
- Termination date;
- Deductible met (yes or no) for current and prior year;
- HMO data:
  - HMO name;
  - HMO zip code;
  - HMO code (cost or risk);
  - Entitlement date;
  - Termination date; and
- MSP activity.

Providers may use any computing device currently used for electronic billing to inquire about beneficiary eligibility utilization and deductible status. Carriers will offer this beneficiary eligibility utilization and deductible status information on a computer to computer telecommunication file transfer basis. Carriers are free to offer providers an optional interactive screen access at their own expense. CWF is the source record for eligibility and as a consequence, substitution of local history is not allowed. Providers cannot have access to any CWF data not specified in this instruction.

6100.1 Eligibility Data Available.--Advise your Part B providers of the following:

1. Access of eligibility data is only used for submitting an accurate claim;

2. The provider must identify itself to access the data;

3. Eligibility data may not be browsed; i.e., no data will be released except on a beneficiary-specific basis. A provider may send up to 99 names at a time to be verified;

4. Eligibility data is available only to participating physicians and suppliers that bill electronically using the National Standard Format (NSF) or the ANSI X12 837 Health Care Claim Transaction Set;

5. Access will be available to the provider on a "toll" basis; that is, the provider will incur all wire charges;

6. Pertinent technical details are needed to access this data. The following minimum data is required to identify the beneficiary:

- o HICN;
- o Surname;
- o First initial; and
- o Gender.

7. To assure privacy and security while also providing a practical system to operate, the above criteria must match exactly to identify the beneficiary;

8. Services must be rendered independent of the data in accordance with State and local laws regarding access to care;

9. The eligibility data is only good for the time the provider is receiving it. This information could change at any time. Medicare Part B and HMO enrollment and termination dates are the most recent available. Providers must develop for MSP;

10. This data does not represent definitive eligibility status. If the individual is not in file, the provider must use the usual billing procedures in effect independent of this data access;

11. It is important that providers use the patient ID field provided for them in both incoming and outgoing records. We will not edit for this field, but will return it when it is present. It will be the only way a return, bearing corrected patient name or number, can be matched by the receiver; and

12. Medicare eligibility information is confidential and the penalties available under the Privacy Act for illegal disclosure are being found guilty of a misdemeanor and fined not more than $5,000.

6100.2 Contractor Implementation.--Create a beneficiary identification file, with the HICNs of all of your Medicare beneficiaries within the last year, to be used to extract CWF HIQB data from your host. Your CWF host will then provide an initial extract file of eligibility data based on the HICN match. The extract file will house only the required eligibility information. You will use this file to pass eligibility data to your providers.

Every 24 hours, your host(s) will send you an extract file of updated transactions since the last transmission. Please contact your CWF host site for details regarding this update. You will apply the updated transactions to your extract file. Newly accreted beneficiaries or any beneficiary for which you have received a bill for the first time will not result in CWF sending a response with Part B eligibility data to you. If you want the data,

you must submit an extract request. This can be initiated because of the first bill or you can wait until the provider requests data. Every 18 months, send a file of deletions to be purged from your eligibility file to your host so that file sizes can be maintained. You will return inquiries against your in-house extract file as soon as possible, given your available computer capacity, but not later than 24 hours after you have received an inquiry.

An out-of-service area inquiry will be sent directly to your CWF host. The host response is then rerouted back to you. Return the response to the provider within 3 days.

There are five responses to be returned to the provider. The codes conform to ANSI ASC X12 standards and are specified in the Beneficiary Detail Response Record. They are:

- Definitive reply;
- Still searching, will respond later;
- Invalid or missing HICN;
- Missing patient name; or
- Name with HICN not found.

Please refer to your CWF documentation for detailed instructions regarding the carrier-CWF host interface.

6100.3 Data Format.--You will use the HCFA national standard flat file format. The American National Standards Institute format will be offered in the near future after it has been tested.

6100.4 Part B Eligibility Data Security Requirements.--Eligibility information must be safeguarded, and unauthorized users must be identified and terminated from the system immediately. Keep a list of access violators for one year. Your system must be able to automatically generate an exception report when:

- An unauthorized user tries to access the system. Disconnect after the first try;

- A nonparticipating provider tries to access your system. If a nonparticipating provider is detected trying to access the system, he/she is blocked from the eligibility access file. He/she may continue to conduct other legitimate business such as submitting claims and receiving remittance advice; and

- Claims to query ratio does not exceed 95 percent. Each quarter your system will compile a report that balances claims against inquiries. To give providers a chance to become familiar with their system, the claims to inquiry ratio will start at 90 percent, and will go up for the next three months until it reaches 95 percent. This means that for every 100 inquiries received, there must be 90 claims submitted the first month, ending with 95 claims submitted for every 100 inquiries after the three month phase-in period. If the claims to inquiry ratio does not exceed 95 percent from a given participating physician or supplier, that physician or supplier will receive an educational contact from you. If there is a problem, or the behavior continues, then the provider loses inquiry access.

6100.5 HCFA Standard Part B Eligibility Inquiry Flat File Specifications.--You must receive these data elements from your providers in this format. If you were one of three HCFA pilot programs, Transamerica Occidental Insurance Company, Health Care Service Corporation (HCSC), or Arkansas Blue Shield, Inc., you may take an additional 6 months to effect a smooth transition with pilot users; do impose these specifications on new users. You must be able to service any provider requesting access to this data in 30 days.

Each record should be terminated with a line feed character, or a line feed and carriage return character combination.

BENEFICIARY HEADER REQUEST RECORD

FLD NO.	FIELD NAME	FLD PICT.	FROM	THRU	REMARKS
l	Header Field	X(4)	1	4	Must be "ELIG."
2	Carrier Number	9(5)	5	9	Your Medicare assigned carrier number.
3	Provider ID	X(10)	10	19	Provider's Medicare number (blank fill).
4	Submitter ID	X(10)	20	29	System ID of the provider, clearinghouse or billing service submitting the request (blank fill).
5	Date & Time Stamp	9(12)	30	41	Date/Time provider transmits records. Julian date (CCYYDDD). Time (HHMMS). Enter the value of "0" for the fifth position (S). Providers and vendors must complete field in the standard format. You should not edit this field, but pass whatever the provider submits in this field to field 3 in response record.
6	Filler	X(4)	42	45	Blank fill.

BENEFICIARY DETAIL REQUEST RECORD

1	Record type	X(1)	1	1	Must be "D." Identifies detail.
2	Patient ID	X(17)	2	18	Reserved for provider use; do not edit.
3	Provider ID	X(10)	19	28	Provider's Medicare number (blank fill).
4	Submitter ID	X(10)	29	38	System ID of the provider, clearinghouse or billing service submitting the request (blank fill).
5	Beneficiary HICN	X(12)	39	50	Enter beneficiary's HICN (blank fill).
6	Beneficiary's Last Name	X(6)	51	56	First six characters of the beneficiary's last name (blank fill).
7	Beneficiary's First Initial	X(1)	57	57	First character of beneficiary's first name.
8	Gender	X(1)	58	58	F=Female, M=Male.

BENEFICIARY TRAILER REQUEST RECORD

1	Total Detail Records	9(2)	1	2	Total number of detail records being sent with this request file (minimum of 1, maximum of 99).

If the eligibility of more than one beneficiary is requested in a single transmission, the second detail request will start immediately after the first detail request. One transmission may contain up to 99 detail requests.

6100.6 HCFA Standard Part B Eligibility Response Flat File Specifications.
You must transmit these data elements to your providers in this format. If you were one of three HCFA pilot programs, Transamerica Occidental Insurance Company, Health Care Service Corporation, or Arkansas Blue Shield, Inc., you may take an additional 6 months to effect a smooth transition with pilot users; do impose these specifications on new users.

Each record should be terminated with a line feed character.

BENEFICIARY HEADER RESPONSE RECORD

FLD NO.	FIELD NAME	FLD PICT.	FROM	THRU	REMARKS
1	Header Field	X(4)	1	4	Must be "RESP." Signifies the beginning of the response file.
2	Carrier Number	9(5)	5	9	Your Medicare assigned carrier number.
3	Date & Time Stamp	9(12)	10	21	Date/time provider transmits records. Julian date (CCYYDDD). Time (HHMMS). Enter the value of "0" for the fifth position (S).
4	Filler	X(24)	22	45	Reserved for future use.

BENEFICIARY DETAIL RESPONSE RECORD

FLD NO.	FIELD NAME	FLD PICT.	FROM	THRU	REMARKS
1	Record Type	X(1)	1	1	Must be "R." Indicates a detail response record.
2	Patient ID	X(17)	2	18	Reserved for Provider use; do not edit.
3	Provider ID	X(10)	19	28	Provider's Medicare number (blank fill).
4	Submitter ID	X(10)	29	38	System ID of the provider, clearinghouse or billing service submitting the request (blank fill).
5	Response Type	9(2)	39	40	Code as follows: 11 = Response (this is a definitive reply).

BENEFICIARY DETAIL RESPONSE RECORD (Cont.)

FLD NO.	FIELD NAME	FLD PICT.	FROM	THRU	REMARKS
					00 = Automatic response. (This is a definitive reply based on a prior request. It is an update to extract data previously sent.) 21 = Still searching; will respond later. 64 = Invalid or missing HICN. 65 = Missing patient name (e.g., surname or first initial). 66 = Missing or invalid gender. 67 = Name with HICN not found. 99 = Problem in system. Cannot process. Please recycle the request. (If inquiry recycles 3 times, inform your host that there is a problem.)
6	HICN	X(l2)	41	52	Beneficiary's Medicare number (blank fill).
7	Last Name	X(6)	53	58	First six characters of beneficiary's last name (blank fill).
8	First Initial	X(1)	59	59	First character of the beneficiary's first name.

FLD NO.	FIELD NAME	FLD PICT.	FROM	THRU	REMARKS
9	Gender	X(1)	60	60	F=Female, M=Male.
10	Medicare Part B Entitlement Date	9(6)	61	66	Beneficiary's entitlement date for Medicare Part B eligibility (MMDDYY).
11	Medicare Part B Termination Date	9(6)	67	72	Beneficiary's Medicare Part B termination date (MMDDYY).
12	Current Year Deductible	9(2)	73	74	Year for the current deductible (YY).
13	Current Year Deductible Indicator	X(1)	75	75	If "Y", deductible is met, if "N", deductible not met.
14	Prior Year Deductible	9(2)	76	77	Year for the prior Year deductible (YY).
15	Prior Year Deductible Indicator	X(1)	78	78	If "Y", deductible met if "N", deductible not met.
16	HMO Name	X(25)	79	103	Current Name of HMO.
17	HMO Zip Code	9(5)	104	108	HMO zip code.
18	HMO Enrollment Date	9(6)	109	114	Give the most current HMO enrollment date (MMDDYY).
19	HMO Termination Date	9(6)	115	120	Give the most current termination date (if applicable) (MMDDYY).
20	HMO Code	X(1)	121	121	C=Cost, R=Risk Space or (blank) = Non-HMO.
21	MSP Activity	X(1)	122	122	D = Develop

FLD NO.	FIELD NAME	FLD PICT.	FROM	THRU	REMARKS
22	Change Code	X(1)	123	123	If yes, beneficiary name or number has been corrected and the correct information returned. Receiver must use their patient ID for matching.
23	Filler	X(7)	124	130	Reserved for future use.
BENEFICIARY TRAILER RESPONSE RECORD					
1	Total Detail Records	9(2)	1	2	Total number of detail records being sent with this request file (minimum of 1, maximum of 99).

NOTE: All dates in the format MMDDYY should default to a value of "000000" when there is no meaningful information in the field.

6100.7 ANSI ASC X12 270 Health Care Eligibility/Benefit Inquiry and the ANSI ASC X12 271 Health Care Eligibility/Benefit Information Transaction Sets.--By October 1, 1996, have in place, ready to test, and in production processing by January 1, 1997, the ability to send and receive the American National Standards Institute (ANSI) Accredited Standards Committee X12 (ASC X12) 270 Health Care Eligibility/Benefit Inquiry and 271 Health Care Eligibility/Benefit Information Transaction Set, version 3051. Refer to the July 1, 1996 ANSI ASC X12 270/271 Implementation Guides for general processing instructions. This information is to be made available to requesting participating physicians and suppliers that bill Medicare electronically using either the National Standard Format or the ANSI X12 837. If you need copies of the ANSI X12 270/271 Implementation Guides, request them from your RO or pull them down from the BPO bulletin board at (410) 786-0215 (Area 3). If there are funding issues, contact your RO.

You are required to:

- Notify all providers immediately about the implementation of the Medicare Part B ANSI ASC X12 270/271 formats and specifications;

- Receive the ANSI ASC X12 270 Health Care Eligibility/Benefit Inquiry directly from the requesting participating providers or their designated billing services;

- Send the ANSI ASC X12 271 Health Care Eligibility/Benefit Information to requesting providers or their designated billing services;

- Issue Medicare Part B specifications for the ANSI ASC X12 270/271 formats to all requesting providers within 3 weeks of the request. Interface specifications must contain sufficient detail that a provider can comply with them without buying a product offered only by you or your subsidiary; and

- Provide assistance to providers at no charge. You must work with providers to correct problems in transmission.